

## LONG TERM CARE FAX REPORTING OF INCIDENTS AND ABUSE

---

### GENERAL INSTRUCTIONS:

1. These instructions apply to reporting all incidents, and suspected abuse, neglect, mistreatment and misappropriation of resident property under the Patient Abuse Law.
2. Complete a separate blank form for each occurrence following the instructions below.
3. Use the attached tables to enter a description for those items that are marked "see table."
4. Submit your completed report by fax to the Department immediately for (1) suspected abuse, neglect or misappropriation; (2) epidemic disease; (3) fires; and (4) death resulting from incidents. **Notify the Department immediately by phone at 617-753-8150 of any deaths resulting from incidents, medication errors, abuse or neglect; and full or partial evacuation of the facility for any reason.** Submit other completed reports within seven days of the date of the occurrence of an incident resulting in serious harm.
5. Fax your completed report to the Department at **617-753-8165**.

### LINE-BY LINE INSTRUCTIONS

#### PAGE 1 OF REPORT FORM:

FROM: Please provide the name and address of the facility making the report.

DATE OF REPORT: Enter the date that you are submitting your report to the Department.

GENERAL INFORMATION: Please indicate your name and title, as the person preparing this report, a phone number at which we can contact you if we need additional information, and the date and time of the occurrence. If you are not able to determine when the event occurred, state "unknown".

RESIDENT INFORMATION: Please provide information here regarding the resident involved. The information reported here should reflect the resident's condition prior to the occurrence. If more than one resident was injured, or one resident has injured another resident, provide additional resident information under the narrative portion of the report or on an additional page. Please indicate:

NAME: The resident's first and last name.

AGE; SEX; ADMISSION DATE: Enter each for the named resident.

AMBULATORY STATUS: Select the term from Table #1, "Ambulatory Status", that most closely describes the resident's ability to walk.

LINE BY LINE INSTRUCTIONS - CONTINUED

**ADL STATUS:** Activities of Daily Living (ADLs) such as eating, dressing or personal grooming. Select the term from Table #2, "Resident ADL Status", that most closely describes the resident's ability to perform these functions.

**COGNITIVE LEVEL:** Select the term from Table #3, "Resident Cognitive Status", that best describes the resident's cognitive status at the time of the occurrence.

**MENTALLY RETARDED/DEVELOPMENTALLY DISABLED:** Indicate whether or not the resident is mentally retarded or developmentally disabled. If the resident is either, indicate the name of the Service Coordinator (mentally retarded) or Case Manager (developmentally disabled) assigned to the patient, if known.

**REPORT DETAIL:**

**OCCURRENCE TYPE:** Select the term from Table #4, "Occurrence Type", that best describes the occurrence you are reporting. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report.

**TYPE OF HARM:** Select the term from Table #5, "Type of Harm", that best describes the harm or injury that resulted from the occurrence. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report. Note that harm includes psychological injury as well as physical harm, and **SHOULD NOT BE DESCRIBED AS "NONE" SIMPLY BECAUSE THERE WAS NO PHYSICAL HARM.**

**BODY PART AFFECTED:** Use terms such as "arm", "foot", etc.; indicate left or right when it applies.

**RESIDENT'S ACTIVITY AT TIME OF OCCURRENCE:** Select the term from Table #6, "Resident's Activity", that best describes the resident's activity at the time of the occurrence. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report.

**PLACE OF OCCURRENCE:** Specify where the event occurred. Examples would include: "resident's room", "dining room", "shower room", or any other short phrase that specifies the type of setting in which the occurrence took place.

**WHAT EQUIPMENT, IF ANY, WAS BEING USED AT TIME OF OCCURRENCE:** Specify if any equipment was in use, such as "Hoyer lift", or "walker".

**ANY SAFETY PRECAUTIONS IN PLACE:** Check the "yes" or "no". If "yes", describe the precautions that were in place.

PAGE 2 OF REPORT FORM:

**NARRATIVE:** Describe fully what occurred. Indicate who, what, when, where, why and how what is being reported occurred. Include information on how any person injured was treated. If there were any unusual circumstances involved, describe these fully.

**CORRECTIVE MEASURES NARRATIVE:** Describe what actions have been taken in response to the occurrence. Note that in the case of abuse, neglect, mistreatment and misappropriation, or injuries of an unknown cause in Medicaid and Medicare certified facilities, federal regulations require that you have evidence that an investigation occurred and the resident was protected from future injury.

**NOTIFICATION:** Indicate whether or not the resident's family and physician, and police were notified. Provide the name of the physician notified. Indicate whether any person injured was brought to the hospital, and if so, the hospital they were brought to.

**STAFF PERSON IN CHARGE OF FACILITY AT TIME OF OCCURRENCE:** Indicate who was in present and charge at the facility (not on the unit) when the occurrence reported happened.

**WITNESS INFORMATION:** List the name and title for individuals who saw or heard what occurred. Indicate if any of witnesses were directly involved in what occurred. Other residents, visitors and volunteers should be listed as witnesses if they have direct knowledge of what occurred.

**ACCUSED INFORMATION:** When reporting suspected abuse, neglect or misappropriation, indicate the name of the accused, a phone number at which the accused can be contacted, if the accused is a nurse, nurse aide or other licensed professional please indicate the individual's license or registration number. Check the appropriate block if you are not reporting abuse, or the identity of the person(s) suspected of abuse, neglect or misappropriation of a resident's money or belongings is unknown. If more than one individual is suspected, indicate on an additional sheet the other individual's names, a phone number at which they may be contacted, and if any person was acting as a nurse aide.

LINE BY LINE INSTRUCTIONS - CONTINUED

REPORTING TABLES:

Table #1: Ambulatory Status:

Independent  
Supervised  
Dependent/Assist  
Wheels Self  
Wheelchair  
Bedfast  
Unknown

Table #2: Resident ADL Status:

Independent  
Supervised  
Dependent  
Unknown  
Other

Table #3: Resident's Cognitive Status:

Alert/Oriented  
Dementia  
Mentally Retarded/Developmentally Disabled  
Confused  
Alzheimer's  
Comatose  
Unknown  
Other

Table #4: Occurrence Type:

Fall  
Abuse  
Neglect  
Misappropriation  
Resident to Resident  
Injury of Unknown Origin  
Epidemic Disease  
Food Poisoning  
Death  
Suicide  
Missing Person  
Criminal Act  
Fire  
Pending Strike  
Choking  
Other (Describe)  
Equipment Malfunction

Table #5: Type of Harm:

Fracture  
Laceration  
Bruise/Hematoma  
Reddened Area  
Dislocation  
Burn  
Unwelcome Sexual Contact/Advance  
Emotional Harm/Upset  
Care Not Provided  
Quality of Care  
Decline in Condition  
Infection  
Confinement  
Property  
Funds  
Death  
No Harm  
Other(Describe)  
Unknown

Table #6: Resident's Activity

Ambulating  
Toileting  
Transfer/Assist  
Getting Out of Bed  
Getting Up From Chair  
Reaching  
Standing/Sitting Still  
Crowded Area  
Unknown  
Other(Describe)

## LONG TERM CARE FAX REPORT FORM

TO: INTAKE STAFF  
DEPARTMENT OF PUBLIC HEALTH, DIVISION OF HEALTH CARE QUALITY  
FAX NUMBER (617) 753-8165

FROM: Facility Name: \_\_\_\_\_  
Address (Street): \_\_\_\_\_  
Address (City/Town): \_\_\_\_\_

DATE OF REPORT: \_\_\_\_\_ NUMBER OF PAGES: \_\_\_\_\_

### GENERAL INFORMATION:

Report prepared by: \_\_\_\_\_  
Title: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
Date of Occurrence: Month \_\_\_\_\_ Date \_\_\_\_\_ Year \_\_\_\_\_  
Time of Occurrence: \_\_\_\_\_ am \_\_\_\_\_ pm \_\_\_\_\_

### RESIDENT INFORMATION:

Name: First \_\_\_\_\_ Last \_\_\_\_\_  
Age: \_\_\_\_\_  
Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
Admission Date: Month \_\_\_\_\_ Date \_\_\_\_\_ Year \_\_\_\_\_  
Ambulatory Status (See table #1): \_\_\_\_\_  
ADL Status (See table #2): \_\_\_\_\_  
Cognitive Level (See table #3): \_\_\_\_\_  
Mentally Retarded/Developmentally Disabled: \_\_\_\_ Yes \_\_\_\_ No  
If yes, Service Coordinator or Case Manager (if known): \_\_\_\_\_

### REPORT DETAIL:

Occurrence Type (See table #4): \_\_\_\_\_  
Type of Harm (See table #5): \_\_\_\_\_  
Body Part Affected: \_\_\_\_\_ L: \_\_\_\_ R: \_\_\_\_  
Resident's activity at time of occurrence (See table #6): \_\_\_\_\_  
Place of Occurrence: \_\_\_\_\_  
What equipment, if any, was being used at time of occurrence? \_\_\_\_\_  
Any safety precautions in place? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, describe what preventive measures were in place: \_\_\_\_\_

[Form continues to page 2.]

FACILITY NAME: \_\_\_\_\_ DATE OF OCCURRENCE: \_\_\_\_\_

NARRATIVE: (Please address the following: What happened? What factors contributed to the occurrence? Any relevant information which establishes cause? Have there been similar incidents in the past? How were the injuries treated? [Attach additional pages as needed.] )

Were there any unusual circumstances involved? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe. [Attach additional pages as needed.]

CORRECTIVE MEASURES NARRATIVE: (Please address the following: Was there an internal investigation: Yes \_\_\_\_\_ No \_\_\_\_\_. If No - why? If yes - What are the investigation findings? What action was taken with regard to: Resident?; Staff?; Facility practice? What is the resident's current status? What corrective action taken regarding equipment involved, if applicable? [Attach additional pages as needed.] )

NOTIFICATION:

Was family notified: Yes \_\_\_\_\_ No \_\_\_\_\_

Was MD notified: Yes \_\_\_\_\_ No \_\_\_\_\_

Name of MD if notified: \_\_\_\_\_

Was resident brought to hospital: Yes \_\_\_\_\_ (Hospital: \_\_\_\_\_) No \_\_\_\_\_

Were police notified: Yes \_\_\_\_\_ No \_\_\_\_\_

STAFF PERSON IN CHARGE OF FACILITY AT TIME OF OCCURRENCE:

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Directly Involved: YES \_\_\_\_\_ NO \_\_\_\_\_

WITNESS INFORMATION: (Check here if unwitnessed: \_\_\_\_\_)

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Directly Involved: YES \_\_\_\_\_ NO \_\_\_\_\_  
YES \_\_\_\_\_ NO \_\_\_\_\_

ACCUSED INFORMATION: (Check here if unknown or not applicable: \_\_\_\_\_)

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_ CNA \_\_\_\_; RN/LPN \_\_\_\_

If CNA, RN/LPN or other licensed individual, indicate license #: \_\_\_\_\_